Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY SPECIALTY HOSPITALS OF AMERICA
S E HOUSTON CAMPUS
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
15

MFDR Tracking Number
M4-10-2699-01

MFDR Date Received
FEBRUARY 4, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier did not make a legal denial of reimbursement because Provider was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Provider's charges…In this case, the Carrier did not provide a proper explanation in conjunction with the 'W1', payment codes as required by the applicable Division rules and instructions. With regard to payment code 'W1', the Carrier has not according to Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula to include the requested separate reimbursement of implantables as indicated in box #80 of our UB-04. With regard, to payment code '16', Surgery Specialty Hospitals of America, S.E. forwarded all applicable documentation required by Division rules and/or guidelines for the Carrier's review. The information provided by Surgery Specialty Hospitals of America, S.E. was sufficient to support the service provided to the injured worker…It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement…If calculated pursuant to section 134.404(f)(1)(B) and (g), reimbursement should be **$52,251.47**…The carrier made a partial payment of **$43,691.96**. Therefore, the Carrier is required to reimburse Provider in the amount of **$8,559.51**, plus any and all applicable interest."

Amount in Dispute: $8,559.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has issued pymt to Surgery Specialty for DOS 2-4-09-2-7-09 Per the TX…[illegible]…Fee Guidelines allowance."

Response Submitted by: ESIS, P. O. Box 31108, Tampa, FL 33631

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2009 Through February 7, 2009	Inpatient Hospital Surgical Services	$8,559.51	$8,559.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f)(2) and (g) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 24, 2009
   - 150 — PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - (900-030) — CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM.
   - 16 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - (880-016) — CHARGE DENIED DUE TO LACK OF SUFFICIENT DOCUMENTATION AND/OR APPROPRIATE DOCUMENTATION OF SERVICES RENDERED $0.00.
   - W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - (649-006) — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES.
   - (670-007) — SEPARATE REIMBURSEMENT HAS BEEN MADE FOR IMPLANTABLES
   - CV: INVOICES WITH COST ARE NEEDED FOR THE FOLLOWING IMPLANTS: SCREWS 6.0 X 50M X6, SET CAP SCREW X6, PRE-BENT RODS X2, TIGER 9MM SPACER X2, LOT # 05154 MISC 60X60 X 2, BMAC KIT AND GRAFT SELIVERY PACK ARE INCLUDED IN THE TOTAL ALLOWANCE FOR DRG 460 REIM

   Explanation of benefits dated August 31, 2009
   - 150 — PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - (900-030) — CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM.
   - W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - (080) — REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $19,618.50
   - (649-006) — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES.
   - (670-007) — SEPARATE REIMBURSEMENT HAS BEEN MADE FOR IMPLANTABLES

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. Review of the submitted documentation finds a request for separate reimbursement of implantables by the requestor, however the division finds no evidence to support that the carrier did receive the billing certification as required for billing separately for implantables. The division concludes that the request for separate reimbursement of implantables was not in accordance with 28 Texas Administrative Code §134.404(g).
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011." Reimbursement for the disputed services is calculated in accordance with 28 Texas Administrative Code §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 460 is $65,076.61. This amount multiplied by 143% is $93,059.55. The total maximum allowable reimbursement (MAR) is therefore $93,059.55. The respondent previously paid $43,691.96. The requestor is seeking $8,559.51. Therefore an additional amount of $8,559.51 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $8,559.51.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $8,559.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 28, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		September 28, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.